developed other indicators of cost:

1. California Consumer Price Index, as determined by the State Department of Finance.
2. An index developed from the most recent historical data in the long term care industry as reported to OSHPD by providers.

The update factors used by the Department shall be applied to all classes from the midpoint of each facility's fiscal period to the midpoint of the State's rate year in which the rates are effective.

E. Cost-of-Living Update

Adjusted costs for each facility are updated from the midpoint of the facility's report period through the midpoint of the State's Medi-Cal rate year.

Adjusted costs are divided into categories and treated as follows:

1. Fixed or Capital-Related Costs - These costs represent depreciation, leases and rentals, interest, leasehold improvements, and other amortization. No update is applied.

2. Property Taxes - These costs, where identified, are updated at a rate of 2 percent annually, converted to 0.1652 percent per month. Some facilities do not report property taxes---either because they are nonprofit and exempt from such tax or because they have a lease or rental agreement that includes those costs.

3. Labor Costs - A ratio of salary, wage, and benefits (SWB) costs to the total costs of each facility is used to determine the amount of the labor cost component to be updated. The ratio is determined by using the overall ratio of salaries and wages to total costs from data extracted by OSHPD from the labor report, and adding costs that represent all wage-related benefits, including vacation and sick leave.

   The labor costs for ICF/DD-Hs and ICF/DD-Ns are facility-specific, obtained directly from each cost report in the study. Labor costs for each facility are updated from the midpoint of its cost reporting period to the midpoint of the

State's rate year.

4. All Other Costs - These costs are the total costs less fixed or capital-related costs, property taxes, and labor costs. The update for this category utilizes the California Consumer Price Index (CCPI) for "All-Urban Consumers" and figures projected by the State Department of Finance.

F. The reimbursement rate per patient day shall be set at the median of projected costs for the class, as determined above, except that:

1. NF-B services, excluding subacute and pediatric subacute, which are provided in distinct parts of acute care hospitals, shall be reimbursed at the lesser of costs as projected by the Department or the prospective class median rate.

2. NF-A services provided in distinct parts of acute care hospitals shall be reimbursed at the applicable NF-A rate for freestanding facilities in the same geographical area location.

3. Rural hospitals are identified each year by OSHPD. For those rural hospitals with Medi-Cal distinct part nursing facility days, their rates, as determined for the DP/NF-B level of care, are arrayed and the median rate is applied to all rural swing bed days. Facilities that report no Medi-Cal days, have an interim rate, or submit only a partial year cost report are excluded from the swing bed rate calculation.

4. NF services provided in a facility which is licensed together with an acute care hospital under a single consolidated license, yet fails to meet the definition of a DP/NF, shall be reimbursed at the applicable rate for freestanding facilities.

5. As long as there is a projected net increase in the California Consumer Price Index during the State's fiscal year previous to the new rate year, no prospective rate of reimbursement shall be decreased solely because the class median projected cost is less than the existing rate of reimbursement. In the event the existing prospective class median is adopted as the maximum reimbursement rate for DP/NF-Bs and subacute units providers with projected costs below the existing class median shall be reimbursed their projected costs as determined in the most recent rate study.

In the event there are components in the previous rate study that increased the reimbursement rate to compensate for time periods prior to the effective date of the rates, the rates shall be adjusted (for purposes of determining the existing rate) to reflect the actual per diem cost without the additional compensation. As an example, assume that the per diem cost of a new mandate was $.10. The new mandate was effective June 1, 1997, but the rates were not implemented until August 1, 1997. The rates would include an add-on of $.117 ($.10 times 14 months, divided by 12 months) to compensate 14 months add-on over a 12 month rate period.

6. If a DP, formerly licensed as a freestanding facility, has costs less than the freestanding median rate for their group, their rate will not be reduced to less than the median solely because of the change to distinct part licensure.

7. DPs in areas where there are excess freestanding beds may accept patients at the area's highest NF-B rate to assure greater access to Medi-Cal patients and to provide a savings to the program.

8. State operated facilities shall be reimbursed their costs as reflected in their cost reports, in accordance with the provisions of this plan, using individual audit data for adjustments. These costs are not to be included in the calculation of the class median rate for all other DP/NF level Bs.

9. ICF/DDs (except state operated facilities), ICF/DD-H and ICF/DD-N facilities will be reimbursed at the 65th percentile, instead of the median, in recognition of the fact that they serve a disproportionate share of low income patients with special needs.

10. Subacute services which are provided in both distinct parts of acute care hospitals and freestanding NFs shall be reimbursed at the lesser of costs as projected by the Department or the prospective class median rate, broken down by ventilator and non-ventilator and DP or freestanding NF.

11. The subacute rate includes additional ancillary costs. Where available, the facility's projected cost is based on the audited ancillary cost data. In the event that audited ancillary costs are not available, the facility's projected cost is based on the median of the projected subacute ancillary costs of the facilities in the study that have audited ancillary costs.

12. For purposes of setting the DP/NF or subacute prospective class median rate, the Department shall use the facility's interim projected reimbursement rate when their audit report is not issued as of July 1st.

13. Transitional inpatient care is reimbursed based on a model rate in accordance with Section V.A. of this Attachment.

14. Each year the current rate for NF-A 100+ bedsize will be increased by the same percentage of increase received by other NF-level As. The term percentage increase means the average increase, weighted by patient days.

G. Notwithstanding paragraphs A through E of this Section, prospective rates for newly licensed DP/NF-Bs shall be based on the facility's historical costs of providing NF-B services regardless of ownership or licensure.

For DP/NF-Bs with historical costs as a licensed freestanding NF-B, the Department shall establish a prospective DP/NF-B rate based on the freestanding NF-B cost report. If the newly licensed DP/NF-B has reported costs as both a freestanding NF-B and DP/NF-B, the Department shall establish the facility's historical-costs basis by combining the freestanding NF-B and DP/NF-B total patient days and costs. Newly licensed DP/NF-Bs shall receive prospective rates based on available freestanding NF-B cost reports until the Department uses the consolidated hospital DP/NF-B cost report and/or audit in the appropriate rate study.

Newly licensed DP/NF-Bs without historical costs of providing NF-B services shall receive an interim reimbursement rate. This interim rate shall be based on the DP/NF-B's projection of their total patient days and costs, as approved by the Department. When actual DP/NF-B audit report data becomes available, interim rates will be retroactively adjusted to the DP/NF-Bs final prospective rate. Final DP/NF-B rates may be less than the interim rate, in which case the Department shall recover any overpayment.

H. Subacute providers that do not have historical costs shall receive an interim reimbursement rate. This interim rate shall be based on the subacute facility's projection of their total patient days and costs, as approved by the Department. When actual subacute audit report data becomes available, interim rates will be retroactively adjusted to the subacute facility's final prospective rate. Final rates may be less than

the interim rate, in which case the Department shall recover any overpayment. Only subacute providers participating in the program as of June 1st will be included in the rate study.

V. DETERMINATION OF RATES FOR NEW OR REVISED PROGRAMS

A. When the State adopts a new service or significantly revises an existing service, the rate of reimbursement shall be based upon comparable and appropriate cost information which is available. Comparable rate and cost data shall be selected and combined in such a manner that the rate is reasonably expected to approximate median audited facility costs, had accurate cost reports been available for the particular class of facility. Such factors as mandated staffing levels and salary levels in comparable facilities shall be taken into account. This method of rate-setting shall ordinarily be relied upon to set rates only until such time as accurate cost reports which are representative of ongoing operations become available.

B. When it is determined that cost report data from a class of facilities is not reliable for rate-setting purposes due to inaccuracies or reporting errors, a random sample of such facilities shall be selected for audit and the resulting audited costs shall be used for the rate study.

C. After five years from the end of the fiscal year in which a facility begins participating in a program for Medi-Cal reimbursement, the reimbursement rate methodology will either revert to the provisions described in Section I through IV of Attachment 4.19-D or be subject to new provisions as described in a State Plan amendment.

VII. PUBLIC CONSIDERATION

A. A public comment period is provided, during which a public hearing may be requested by interested parties. During this period, the evidentiary base and a report of the study methodology and findings are available to the public.

1. Interested parties will be notified of the time and place of the hearing (if scheduled), and the availability of proposed rates and methodologies by direct mail and public advertising in accordance with state and federal law.
2. Comments, recommendations, and supporting data will be received during the public comment period and considered by the Department before certifying compliance with the state Administrative Procedures Act.
3. As part of the final regulation package, the Department will respond to all comments received during the public comment period concerning the proposed changes.

VIII. PUBLIC HOSPITAL DP/NF ADDITIONAL REIMBURSEMENT

This program provides additional reimbursement for a DP/NF of a general acute care hospital that is owned or operated by a city, county, city and county, or health care district, which meets specified requirements and provides nursing facility services to Medi-Cal beneficiaries.

Additional reimbursement under this program is available only for the federal share of costs that are in excess of the rate of payment the facility receives for nursing facility services under the current DP/NF reimbursement methodology and any other source of Medi-Cal reimbursement for DP/NF services.

A. Definition of an Eligible Facility

A facility is determined eligible only if the submitting entity continuously has all of the following additional characteristics during the Department's rate year beginning August 1, 2001, and subsequent rate years:

1. Provides services to Medi-Cal beneficiaries.

2. Is a DP/NF of an acute care hospital providing nursing facility care. For purposes of this section, "acute care hospital" means the facilities described at subdivision (a) or (b), or both, of Section 1250 of the Health and Safety Code.

3. Is owned or operated by a city, county, city and county, and/or health care district organized pursuant to Chapter 1 of Division 23 (commencing with Section 32000) of the Health and Safety Code.

Owners of eligible facilities must provide certification to the state that the amount claimed by them is eligible for federal financial participation.

B. Additional Reimbursement Methodology

Additional reimbursement provided by this program to an eligible nursing facility is intended to allow federal financial participation for certified public expenditures.

1. As described in paragraph A, the expenditures certified by the local agency to the state shall represent the payment

eligible for federal financial participation. Allowable certified public expenditures shall determine the amount of federal financial participation.

2. In no instance shall the amount certified pursuant to paragraph C.1 , when combined with the amount received from all other sources of reimbursement from the Medi-Cal program, exceed 100 percent of the projected costs (as determined pursuant to Sections I through V of this Attachment 4.19-D) for DP/NF services at each facility.

3. Costs associated with the provision of subacute services pursuant Section 14132.25 of the Welfare and Institutions Code will not be certified for reimbursement pursuant to this section.

4. The additional Medi-Cal reimbursement provided by this section shall be distributed under a payment methodology based on skilled nursing services provided to Medi-Cal patients at the eligible facility. The provider shall report to the Department, on a quarterly basis, the amount of the eligible costs that are the lesser of actual costs or the Department's projected costs for that facility. In no case shall total annual reimbursement under this section exceed the Department's projected costs.

C. Facility Reporting Requirements

The governmental entity reporting on behalf of any eligible facility must do all of the following:

1. Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for DP/NF services are eligible for federal financial participation.

2. Provide evidence supporting the certification as specified by the Department.

3. Submit data as specified by the Department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.

4. Keep, maintain and have readily retrievable, such records as specified by the Department to fully disclose reimbursement amounts to which the eligible facility is entitled, and any other records required by the Centers for Medicare and Medicaid Services.

D. Standards for Additional Reimbursement

1. The Department may require that any city, county, city and county, or health care district receiving additional reimbursement under this program enter into a written interagency agreement with the Department for the purposes of implementing this program.

2. Additional reimbursement paid under this program must not be greater than the difference between total projected Medi-Cal costs and the amount paid under the existing DP/NF reimbursement methodology specified in Sections I through V of this state plan.

3. The total Medi-Cal reimbursement received by a facility eligible under this program will in no instance exceed 100 percent of the projected costs (as determined pursuant to Sections I through V of this state plan) for DP/NF services at each facility.

E. Department's Responsibilities

1. The Department will submit claims for federal financial participation for the expenditures for services that are allowable expenditures under federal law.

2. The Department will, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

3. The state share of the additional reimbursement under this program will be equal to the amount of the federal financial participation of eligible expenditures paid by city, county, city and county and/or health care district funds and certified to the state as specified in Section C.1 above.

4. Total Medicaid reimbursement provided to an eligible facility will not exceed applicable federal upper payment limits.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.